ARC 8977B

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249J.24 and 2010 Iowa Acts, Senate File 2356, section 1, and House File 2531, section 201, the Department of Human Services proposes to amend Chapter 92, "IowaCare," Iowa Administrative Code.

The proposed amendments make the following changes in IowaCare premium policies to satisfy federal requirements:

- Recalibrate premium amounts to provide that no premium payment is required for households with income at or below 150 percent of the federal poverty level and that premiums are limited to 3.5 percent of the applicable income level. A single premium will be set for the household, rather than a separate premium for each IowaCare member. A separate table is used to determine the premium for a household containing two or more IowaCare members.
- Delay cancellation of benefits for failure to pay a premium until 60 days after the premium due date.
- Allow IowaCare members whose benefits have been canceled due to nonpayment of premiums to reapply and be approved even if payments from a previous certification period remain unpaid.

The proposed amendments also make the following changes to the IowaCare provider network and services as directed by state legislation:

- Add federally qualified health centers as IowaCare providers. Centers will be phased in as IowaCare providers as funding permits.
- Add coverage of emergency medical services rendered by providers that do not participate in IowaCare, under limited and specified conditions.
- Add requirements for "medical home" services and corresponding reimbursement.
- Clarify reimbursement methodologies for participating and nonparticipating providers.

These amendments do not provide for waivers in specified situations. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

Any interested person may make written comments on the proposed amendments on or before August 17, 2010. Comments should be directed to Mary Ellen Imlau, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by E-mail to policyanalysis@dhs.state.ia.us.

These amendments are intended to implement Iowa Code chapter 249J as amended by 2010 Iowa Acts, Senate File 2356, section 1, and House File 2531, section 201.

The following amendments are proposed.

ITEM 1. Amend rule **441—92.1(249A,249J)**, definition of "Medical expansion services," as follows:

"Medical expansion services" means the services described in Iowa Code ~~Supplement~~ section 249J.6.

ITEM 2. Adopt the following **new** definitions in rule **441—92.1(249A,249J)**:

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health

potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

"Provider-directed care coordination services" means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.

"Nonparticipating provider" means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

ITEM 3. Amend subrule 92.2(5) as follows:

92.2(5) *Payment of assessed premiums.* ~~As a condition of eligibility for IowaCare, an applicant or member must pay~~ IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). ~~Premiums incurred and unpaid from a previous certification period must be paid in full before an applicant can establish new eligibility under this chapter.~~ However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

ITEM 4. Amend subrules 92.3(1) and 92.3(2) as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department's request.

92.3(2) A new application is required for each ~~12-month~~ certification period.

ITEM 5. Amend subrule 92.6(1) as follows:

92.6(1) *Certification period.* IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months ~~or~~. EXCEPTIONS:

a. ~~for~~ For women and newborns eligible under 92.2(1)*"b"* or *"c,"* the certification period shall continue until 60 days after the birth of the child.

b. Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

ITEM 6. Amend rule 441—92.7(249A,249J) as follows:

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c,"* and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. ~~No premium shall be assessed at the time of initial application for months of eligibility before and including the month of decision, including the retroactive month.~~ A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for ~~a 12-month~~ the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for ~~the 12-month period~~ 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

a. The monthly premium ~~amount~~ is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Effective ~~April 1, 2009, premium amounts based on this percentage~~ for applications and recertifications received on or after October 1, 2010, premiums are as follows:

When there is one IowaCare member in the household and the household's income is at or below:	~~Each~~ The member's premium amount is:
~~100% of federal poverty level~~	~~$ 0~~
~~110% of federal poverty level~~	~~$45~~
~~120% of federal poverty level~~	~~$49~~
~~130% of federal poverty level~~	~~$54~~
~~140% of federal poverty level~~	~~$58~~
150% of federal poverty level	~~$63~~ $0
160% of federal poverty level	~~$67~~ $47
170% of federal poverty level	~~$72~~ $50
180% of federal poverty level	~~$76~~ $53
190% of federal poverty level	~~$81~~ $56
200% of federal poverty level	~~$85~~ $60

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$63
170% of federal poverty level	$68
180% of federal poverty level	$72
190% of federal poverty level	$76
200% of federal poverty level	$80

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment ~~for a one-person household~~ of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below ~~100~~ 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over ~~100~~ 150 percent of the poverty level are ~~5~~ 3.5 percent of the lowest applicable income level. The department will update these amounts ~~annually on April 1 using the latest~~ effective the second month after the month federal poverty level guidelines are released.

c. The cost of HAWK-I premiums paid for ~~HAWK-I~~ household members shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a ~~12-month~~ certification period shall not be increased due to an increase in household income or a change in household size.

e. The premium may be reduced prospectively during the ~~12-month~~ certification period if ~~the~~ a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. No change.

b. Due date. When the department notifies ~~the~~ a member of the amount of the ~~premiums~~ premium, the member or household shall pay any premiums due as follows:

(1) and (2) No change.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month ~~forward~~ in the current certification period. When premiums for all months in the

certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member ~~who~~ or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."* If the statement is not postmarked by the premium due date, the member or household shall be obligated to pay the premium.

a. and *b.* No change.

c. A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective ~~the last day of the next calendar month~~ 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

a. ~~The premium obligation is reduced to zero~~ Premiums may be refunded when a member's IowaCare coverage is canceled because the member:

(1) to (5) No change.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for ~~an individual~~ a person who is not receiving IowaCare benefits shall be refunded:

(1) ~~after two~~ Two calendar months after eligibility ended unless an application or reapplication is pending, or

(2) ~~upon~~ Upon the ~~individual's~~ person's request.

d. Any excess premium received for an IowaCare member shall be refunded:

(1) ~~after~~ After two calendar months of a zero premium, or

(2) ~~upon~~ Upon the member's request.

ITEM 7. Amend subrules 92.8(1), 92.8(2) and 92.8(4) as follows:

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) through ~~92.8(5)~~ 92.8(6), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A ~~state mental health institute, exclusive of the units providing substance abuse treatment, services to gero-psychiatric patients, or treatment for sexually violent predators~~ federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78~~,~~ or 441—79.9(249A)~~,~~ and ~~441—Chapter 85, Division I~~ to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center~~.~~ that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1)*"c."* Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. No change.

ITEM 8. Adopt the following **new** subrules 92.8(6) and 92.8(7):

92.8(6) *Medical home.* As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

a. The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

(1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.

(2) Provide provider-directed care coordination services.

(3) Provide members with access to health care and information.

(4) Provide wellness and disease prevention services.

(5) Create and maintain chronic disease information in a searchable disease registry.

(6) Demonstrate evidence of implementation of an electronic health record system.

(7) Participate in and report on quality improvement processes.

b. The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall enroll the member with that provider. A member who is enrolled with a medical home provider:

(1) Shall utilize the medical home provider for covered services available from that provider, and

(2) Must receive a referral from the medical home provider to another IowaCare provider for any services not available from the medical home provider.

92.8(7) *Emergency services from nonparticipating providers.*

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.

(2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.

(3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.

(4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.

(5) The treating nonparticipating provider has consulted with the IowaCare provider network hospital and the providers jointly agree that the conditions for payment are met.

(6) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services and documentation of the consultation with the IowaCare network provider.

b. If the conditions listed in paragraph *"a"* are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

ITEM 9. Amend rule 441—92.9(249A,249J) as follows:

441—92.9(249A,249J) Claims and reimbursement methodologies.

92.9(1) *Claims.* Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

92.9(2) *Payment for hospital services provided by IowaCare network.* Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

(1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.

(2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital's CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital's cost report. For purposes of this rule, aggregate payments include amounts received for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

92.9(3) *Payment for nonhospital services provided by IowaCare network.* Effective July 1, 2010, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts in effect on November 30, 2009, with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Physician services provided to IowaCare members in a federally qualified health center shall be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

92.9(4) *Medical home payments.*

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The

medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than $4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

92.9(5) *Payment for services provided by nonparticipating hospitals.* Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

92.9(6) *Payment for services provided by other nonparticipating providers.* Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.

ITEM 10. Amend rule 441—92.13(249A,249J) as follows:

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

92.13(1) The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

92.13(2) No change.